Leicester City Council

Report to Scrutiny Commission

Adult Social Care

Date of Commission meeting: 4th August 2015

BETTER CARE FUND: UPDATE REPORT

Report of the Director of Adult Social Care and Safeguarding

Useful Information:

- Ward(s) affected: All
- Report author: Ruth Lake, ASC and Safeguarding, LCC
  Rachna Vyas, Head of Strategy and Planning, Leicester City CCG
- Author contact details 454 5551
- Date of Exec meeting N/A

1. Purpose of report:

1.1 To provide the Adult Social Care Scrutiny Commission with an update on the progress of the Leicester City Better Care Fund (BCF), highlighting those schemes that relate directly to Adult Social Care (ASC).

1.2 The detail of the Better Care Fund has previously been presented to the commission (March 2015) and this is a further update report.

1.3 This report draws out some of the equality impact analysis that is available from the BCFschemes.

2. Key issues or points to note

2.1 The Leicester City Better Care Fund interventions focus on enabling 'flow' across the health and social care system. This is helping to stop people being unnecessarily brought in to the acute care system or becoming stuck within it after they are well enough to go home. It is also focussed on reducing long term residential and nursing care, supporting people to remain in their own homes.

2.2 The BCF programme is primarily scrutinised by the Health and Wellbeing Board, this being a requirement in the BCF national guidance. The Joint Integrated Commissioning Board oversees progress and issues on a monthly basis. The impact of the schemes on the acute care system, and those schemes which are delivering new health services, will be of interest to the Health Scrutiny Commission.

2.3 Presently the BCF is supporting existing ASC services in order to extend their availability and maximise their benefit to people at risk of emergency admissions, rather than delivering new services.

2.4 Performance against the nationally prescribed indicators is positive for all indicators except the emergency admission indicator, which is currently showing 15.6% over the 13/14 baseline.

2.5 The BCF work in Leicester has attracted positive interest, from ministers nationally and also from the BCF Exchange, following a regional showcase. The services to manage crisis in the community and to divert people from unnecessary hospital admission have been particularly noted.

2.4 All BCF funded services were evaluated prior to the start of 15/16 and new funding allocations made. This brought further investment in to ASC to extend the Integrated Crisis Response Service, as well as maintaining allocations to support 7 day services.

3. Recommendations

The Adult Social Care Scrutiny Commission is recommended to note the progress made and the positive impacts being achieved.

4. Summary of Interventions

The table below summarises the key progress made in each scheme. Those which relate to ASC activity are highlighted.

Scheme	Scheme status
Priority 1: Prevention, early detection and improvement of health-related quality of life	
BCF1 Risk stratification	**LIVE** ▪ ISA enabling further use of Risk Stratification in commissioning has been agreed by the LMC and is being circulated to data controllers in practices through July and August. All practices expected to sign agreements by Sept 1st 2015. This will enable population segmentation, profiling and disease burdens at General Practice level to inform future models of delivery.
BCF 2 Lifestyle Hub	**LIVE** ▪ Provider in place and delivering across City. Referral numbers are lower than planned and therefore service is being pushed at every opportunity by both provider and CCG teams. ▪ Approximately 300 referrals per month being taken, with a service capacity of 500. ▪ New SystMone template covering all Lifestyle Hub interventions in one template will be live from Sept 1st for use in General Practice ▪ Web based system (www.gethealthyleicester.co.uk) live and in use
BCF 3 General Practice scheme (2.1-5%)	**LIVE** ▪ New BCF care plan template being trialled, which takes into account the learning from the Care Plan audit and City GP feedback. ▪ Will be formally launched in conjunction with the new Primary Care Activity Scheme which encourages practices to complete care plans plus refer into a wider range of BCF services in order to reduce acute activity.

Priority 2: Reducing the time spent in hospital avoidably	
BCF 4 Clinical Response Team	**LIVE** ▪ Activity has steadily increased following a period of targeted engagement with various high users of the urgent care system, such as domiciliary care providers, EMAS Clinical Assessment Team and General Practice. ▪ Service saw 430 patients in June 2015 with 89% of these kept at home ▪ 65% were from GP's and 35% were from care homes. Qualitative data from the care homes suggest that they would have called 999 if this service was unavailable. ▪ Clinical audit underway to validate data for QIPP (quality, Innovation, Productivity and Prevention) reporting purposes.
BCF 5 Unscheduled Care Team	**LIVE** ▪ In 14/15 the Integrated Crisis Response Service (ICRS) saw **3895** people, all within 2 hours of referral ▪ **1,010** of these had fallen: after checking and supporting, only **11** of these people needed to be **conveyed into hospital.** The rest were kept safely at home ▪ Number of people where care was shared with health: **1565** ▪ Over 75% of ICRS cases require no further services after our integrated approach ▪ 320 patients accessed the Reablement pathway ▪ ICRS saw 429 patients in June, with 141 of these being fallers. ▪ 95 patients were supported home from acute hospital with qualitative data showing that this has impacted on readmissions for this cohort. ▪ Referrals from other parts of the system such as GPs and SPA have also increased. ▪ The teams across health and social care expect to be co-located by Sept 1st and this will aid efficiency across the unscheduled care team for both health and social care. ▪ Night nursing services have also seen an increase in referrals with the roving City service attending to an average of 1 patient a night. The service also provides cover for the overnight element of the ICRS team. Data is being collected for this element.
BCF 6 System Coordinator	**Not taken forward**
BCF 7	**LIVE** ▪ 36 ICS beds are live, with daily occupancy reaching ~92%.

Intensive Community Support service	▪ Feedback from LPT teams is that the virtual beds are enabling much faster discharge from LPT and UHL beds, enabling system-wide flow and reducing DTOC's, most notably during peak times.
BCF 8 IT integration	**LIVE** ▪ Records have started to be merged as the NHS number is now being used across health and social care.
Priority 3: Enabling independence following hospital care	
BCF 9 Planned Care Team	**LIVE** ▪ ASC has now commenced a review to implement the management and team structure to support integrated planned care teams. Due to conclude Autumn 2015 ▪ In June, the Care Navigator service had 94 patients referred in, with the majority of these patients being over 75 and at high risk of admission ▪ This is significantly under the available capacity and the CCG and LA are working collaboratively to increase the referrals by trialling a more proactive delivery model. This will involve visiting practices with higher numbers of older patients and offering the service directly to an identified patient cohort in partnership with the practice.
BCF 10 Mental health discharge team	**LIVE** ▪ Work is ongoing at Commissioner level to unblock these delays as LPT has been unable to aid a further decrease in DTOC's seen during the latter part of 14/15.
BCF 11 Integrated Mental health step down service	**NOT LIVE** ▪ Held whilst ongoing LLR mental health pathway review takes place.

5. Quality and Performance

Case Study

Whilst case studies are not in themselves the total measure of performance, they can be powerful in highlighting how the changes made are experienced by people and the outcomes that can be achieved.

April 2015

Mrs T was referred to ICRS by the Clinical Response Team due to numerous falls. She had recently attended hospital but was discharged without further support. When she had fallen before, she had spent a long time on the floor; she had relied on neighbours to find her on the floor.

ICRS supported Mrs T with 2 calls daily (am & pm) for a period of 72 hours. They supported her with safe transfer techniques, personal care and confidence building with daily tasks including meal and drink preparation.

ICRS facilitated an urgent referral to the Community Therapy Team who fully assessed her mobility within 48 hours. A referral was also made to Practical Help At Home to install wooden handrails on the stair case which would aid stair transfers and reduce the risk of falls/accidents on the stairs.

LeicesterCare installed a lifeline system within 24 hours and it was requested that ICRS be the first responder if the lifeline activates, so that further falls would be picked up and responded to quickly.

A reassessment took place with the Care Management Officer in ICRS and it was deemed that no further services were required. Mrs T had returned to her previous level of independence and had a plan in place to mitigate the risk and / or impact of any further falls.

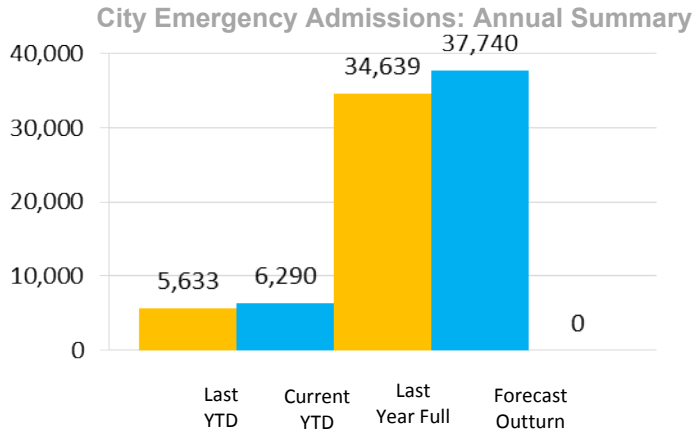
Mrs T noted that she felt more confident, able to carry on at home knowing that if she needed support, it was there. She also noted that the support she received was focussed on getting her back on her feet, rather than her becoming reliant on care, which was something that she feared.

National Performance Metrics

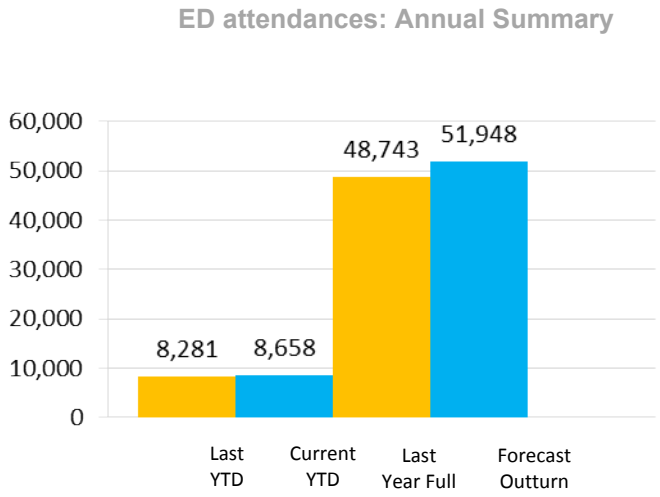
The BCF programme is required to report against a number of national targets

a. Emergency admissions (all ages)

Despite the increase in activity in all areas of the BCF programme, Emergency Department attendances and admissions have continued to increase for Leicester City patients.



UHL Emergency admissions, YTD. GEM BCF dashboard, June 2015

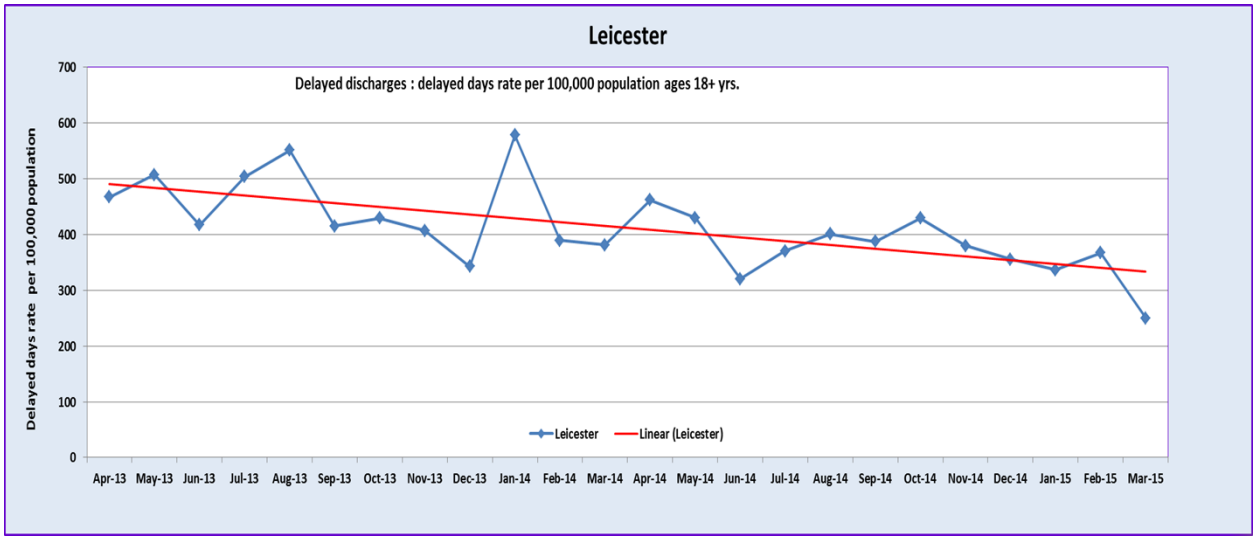


UHL ED attendances, YTD. GEM BCF dashboard, June 2015

However, calls to EMAS have held steady compared to 14/15 YTD, with an increase noted in both non-conveyance and hear and treat services. All services have been requested to upscale work on inflow rather than discharge for 15/16. Work is also ongoing with contracting teams to understand the activity going through UHL and what further opportunity there is to reduce this.

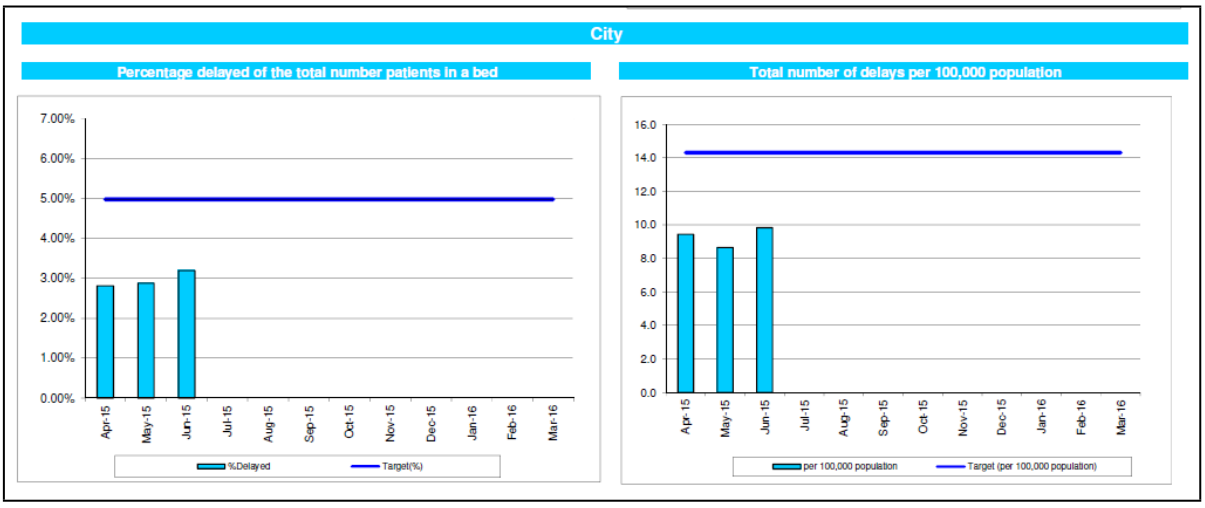
b. Delayed Transfer of Care (DTOC)

Monthly monitoring of the DTOC rate for Leicester City continues to show a steady reduction in numbers, with performance on track to meet the 14/15 trajectory.



Leicester City monthly DTOC rate 2014-15. GEM CSU.

Monthly monitoring shows that City continues to achieve DTOC targets set. As at the end of June 2015, City DTOC rates were 10.2/100,000 against a target of 14.3/100,000. Marked decreases have been noted at UHL as a result on ongoing joint working between BCF teams and the hospital flow team.



There has been an increase in mental health delays recently, predominantly due to a lack of step down facilities for a specific group of high risk patients. Commissioners are working with LPT to tackle this.

c. 65+ Permanent Admissions in residential / nursing homes

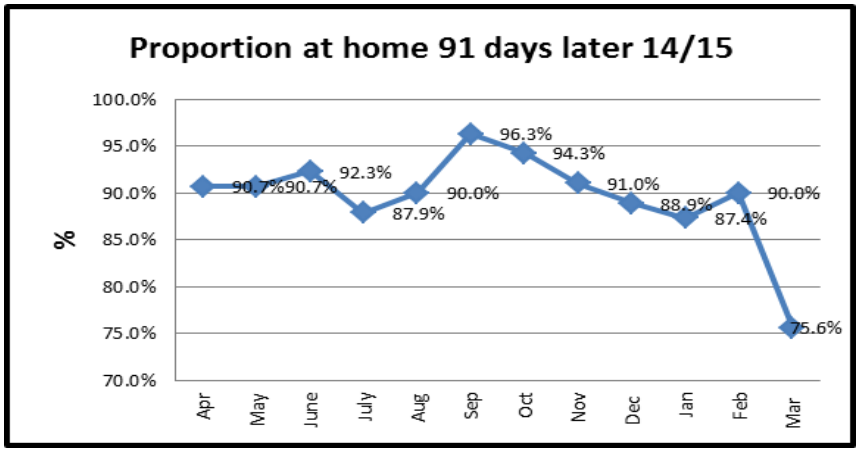
The BCF target for year-end activity was to have no more than 280 admissions in the year. This was missed narrowly, with 287 placements made in total; this was an improvement however on 13/14.

For 15/16, 36 patients to date have been permanently admitted to a residential or nursing home. Forecasting the year end position, we expect to meet our target of 270 admissions based on current activity.

d. Proportion of those aged 65+ at home 91 days later following hospital discharge

Our 2014/15 target for this measure was 89%. Our performance, using the national (ASCOF) reporting methodology (three month window – October to December discharges measured between January and March) was 84.3%. However, when using our local reporting methodology (full year) our performance was 89.7%, exceeding our target.

The discrepancy is largely attributable to an unexpectedly high number of people discharged from hospital in December 2014 dying during the following 91 days. This was approximately 4 times the expected (average) number and accounted for 20.6% of the annual total. This is reflected in the dip in performance in March in the chart below.



6. BCF Risk Management

The BCF risk log is been updated each month and interrogated at each BCF implementation group. No clinical or safety incidents have occurred in any of the BCF interventions outlined above.

7. Equality Impact Assessment

Due to the nature of the schemes they essentially target people who fall into a 'protected characteristic' category, notably age and disability. Therefore there is a wide, positive impact by improving the quality of life for these individuals.

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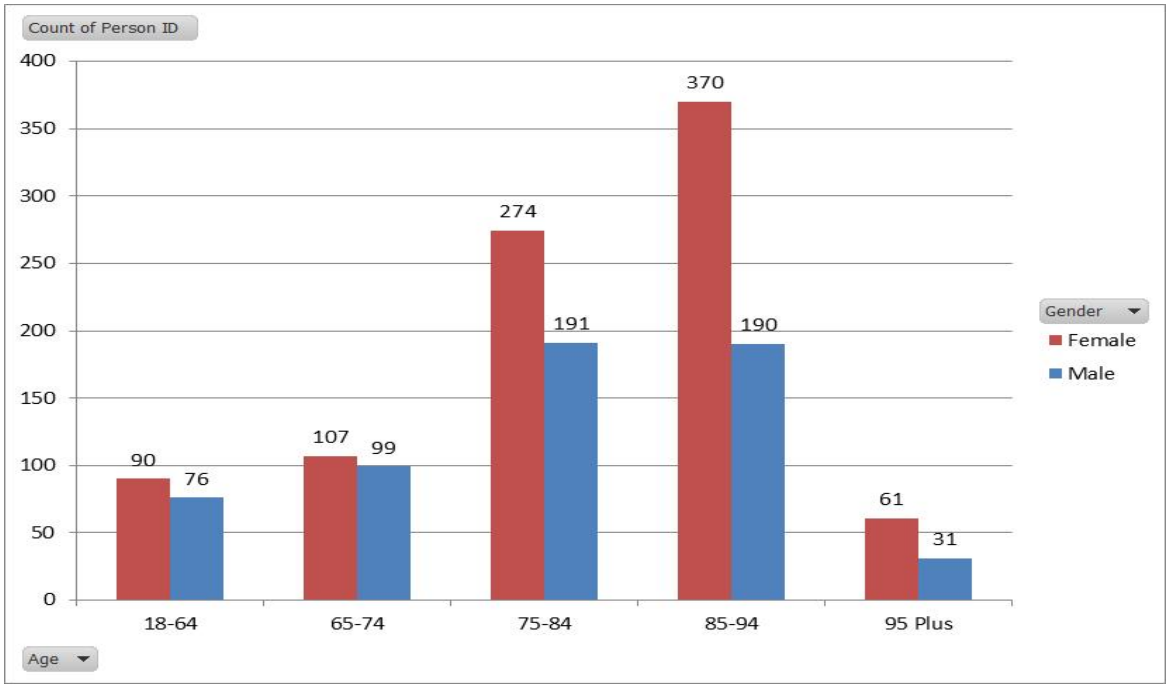
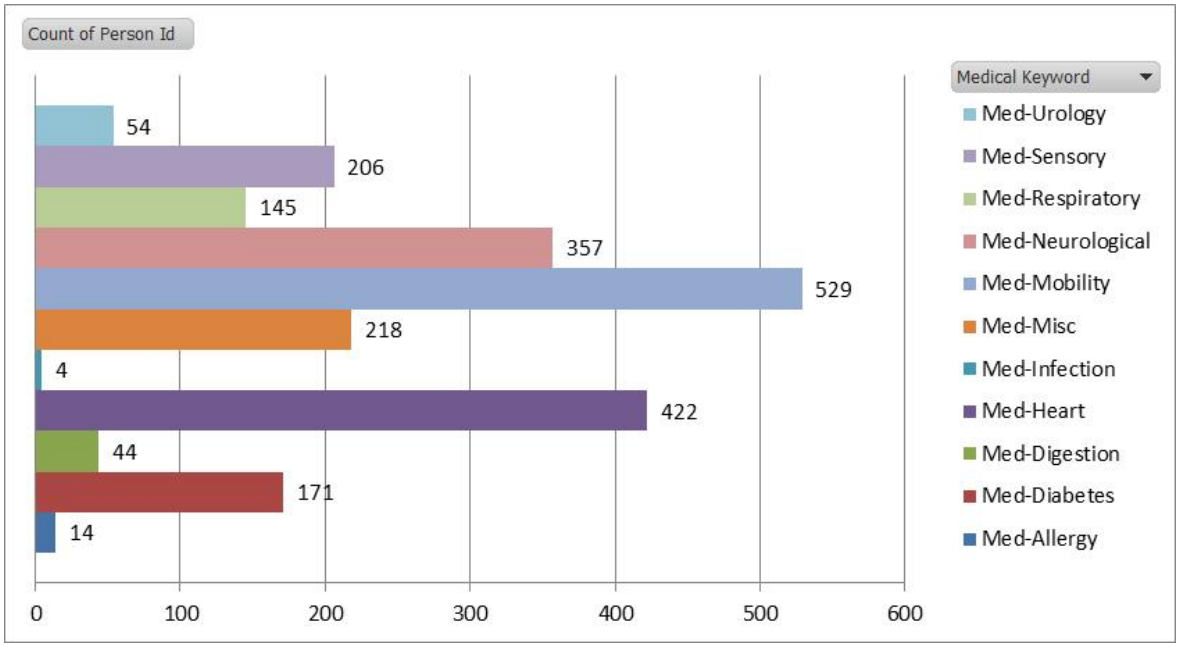
The ICRS data Ethnicity split is 79.7% White compared to BME categories.

ICRS Ethnicity Data	Female	Male	Total
Any other Asian background	3	5	8
Any other Black background	1	2	3
Any other ethnic group	7	8	15
Any other White background	18	13	31
Asian or Asian British – Bangladeshi	1	0	1
Asian or Asian British – Indian	134	94	228
Asian or Asian British – Pakistani	12	8	20
Black or black British - African	5	2	7
Black or black British- Caribbean	12	4	16
Chinese	1	0	1
Information not yet obtained	3	1	4
White British	695	441	1136
White European	3	1	4
White Irish	7	8	15
Grand Total	**902**	**587**	**1489**

The Age vs Gender analysis of the ICRS data shows an overall higher proportion of females supported by ICRS. This is comparable to national age vs gender demographics. The ICRS data also highlights a prominence of the service supporting individuals above the age of 75.



An analysis of the LeicesterCare data for service users with ICRS as a designated responder indicates that BCF funded services support the needs of service users with a wide range of medical conditions, predominantly service users with Mobility, Heart, and various Neurological medical conditions.



8. Looking ahead

The funding position past 15/16 is not certain, as Councils and CCGs are awaiting confirmation from central government. It should be noted that aside from the specific schemes described above, a significant sum (£13m) is coming to the Council to support the provision of general social care services.

Clarity has been sought regarding the status of BCF funding for 16/17 to enable planning. As yet, nothing has been received from either NHS England or the Local Government Association, although a decision is expected by autumn 2015. In addition, commissioning guidance is expected in September 2015, outlining the requirement for each area to commission a fully integrated urgent care service which makes reference to ensuring that social care services are specifically considered.

In preparation, a BCF planning workshop will be scheduled in September 2015 to enable the governance process to begin as early as possible.

In terms of an exit plan, for those schemes in operation there has been a clear benefit to the emergency admission levels in the city and decisions would be taken on the basis of effectiveness and the value of continued investment across the wider health and social care system.

8. Financial, legal and other implications

8.1 Financial implications

The total BCF revenue funding for 2015/16 is £21.4m. Of this £13m is being used to supplement the Council's Adult Social Care budget of £88m to support the provision of general social care services. The remainder is being used to fund the various schemes outlined above.

There is uncertainty over BCF funding beyond 2015/16 and therefore there is a significant risk to the Council financial position should the funding be reduced.

Martin Judson, Head of Finance

8.2 Legal implications

The report is to provide the Adult Social Care Scrutiny Commission with an update on the progress of the Leicester City Better Care Fund, and the recommendation is to simply note the progress, thus there are no direct legal implications as a result of this report. Further advice can be sought if required as matters progress.

Amy Owen-Davis
Solicitor
For City Barrister and Head of Standards
0116 4541462